cc Executive Council

Brief 1974-17

A BRIEF

presented by the

ALBERTA DENTAL ASSOCIATION

RESPECTING PRELIMINARY DETAILS OF AN INDEMNITY FORM OF PRE-PAID DENTAL CO-INSURANCE FOR THE PROVINCE OF ALBERTA

Edmonton, Alberta **November, 1971**

Introduction:

In the spring and fall of 1965, the Alberta Dental Association presented two briefs to a cabinet committee of the Government of Alberta. These briefs were entitled "A Dental Care Plan for the People of Alberta", and dealt specifically with the preliminary working details for the provision of dental treatment services through an indemnity form of pre-paid dental co-insurance. At the request of the Hon. Mr. J. D. Henderson, the Alberta Dental Association respectfully submits this brief as a follow-up to the original presentation, thanks to the benefits of six years of social and professional change; however, the comprehensive terms and the underlying philosophies of the plan proposed in this brief are identical with those of its two predecessors.

Within the last six years in our province, many changes in the health field have occurred. The A. H. C. I. C. has taken over as the central agency for the provision of medical health care to our people; and nearly all citizens now subscribe to, and procure medical services through, this medium. It does, however, provide few services in the field of dentistry -- only a few procedures in the field of surgery which may be performed either by doctors of medicine or of dentistry. The majority of dental treatment is not covered at all.

Experience has shown that the cost factor greatly influences people in their seeking of dental services, with those people in the

lower income categories receiving minimal care, even though they usually have the greatest need of dental care. In order that all citizens of this province obtain required dental attention on a more equitable basis, financial support by the Government may be desirable, varying with the financial ability of the patient to pay. At the present time, those people on public assistance -- welfare, old age pension, widow's allowance, etc. -- are having their dental demands met nearly 100% with public funds. Those in a moderate financial category or above can afford dental service if they so choose. Those who fall between these two categories -- the so-called "gray area" -- are of our immediate concern.

In 1964, the Royal Commission on Health Services, referring to the dental program, said the plan "must have one of the highest priorities among all our proposals". Seven years have passed and very little has been done.

We herewith present our proposals for a Dental Care Plan for the Province of Alberta, with related comments and suggestions.

1. All children in the Province of Alberta up to the age of sixteen years be eligible - eventually. Admission to the plan be limited to children ages six and under for the first year. For the second year, ages seven and under; the third year, ages eight and under, etc., until all children ages fifteen and under are admitted.
2. All basic dental treatment and preventive services be provided.
3. Plan to be financed by an indemnity form of pre-paid co-insurance.

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We herewith present our proposals for a Dental Care Plan for the Province of Alberta, with related comments and suggestions.

1. All children in the Province of Alberta up to the age of eighteen years to be eligible - eventually. Admission to the plan be limited to children ages six and under for the first year. For the second year, ages seven and under; the third year, ages eight and under, etc., until all children ages fifteen and under are admitted.
2. All basic dental treatment and preventive services to be provided.
3. Plan is to be supported by an informative [illegible]

(a) To become registered an applicant pays the premium cost.

(b) Children of families whose taxable income is low -- the exact figure to be yet determined -- would obtain government subsidy to pay part or all of the premium cost.

(c) The patient is personally responsible for the "co-insurance" factor, which is the difference between the dentist's usual fee and the indemnity provided by the insurance carrier (i.e. the Alberta Dental Service Corporation) under the terms of the agreement. It is recommended that this program make provision for a schedule of indemnities covering not less than 80% of the Alberta Dental Association suggested fee schedule.

4. Services to be provided by licensed dentists in their private offices or hospitals.
5. Administration to be by the Alberta Dental Service Corporation.
6. Special arrangements be made for delivery of dental service to rural areas.

COMMENTS:

I Personnel and Workload

For the first time in our history, Alberta is approaching the time when there will be sufficient trained dental manpower to meet

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Considerations:

1. [illegible]

For the first time in over 20 years, [illegible]

[illegible] there will be sufficient [illegible] the demand. This is becoming possible because of three major factors.

(a) The increasing role of prevention.

(b) The increasing number of dentists.

(c) The productivity of the dental team.

No other factor can cut down the workload of dentistry as much as prevention. In times past this has meant adequate home care (brushing), proper nutrition, diet, and eating habits. These measures are still important and must always be used. However, the use of fluoridated drinking water, fluoride tooth pastes, fluoride prophylaxis paste, and topical fluoride solutions hold out the possibility of eliminating nearly half of our dental decay. The City of Edmonton and a number of other centres have already added fluorides to their water supply, and hopefully the Government will endorse and actively press for fluoridation in all possible areas of the province.

Ten years ago, Alberta was the only western province with a dental school. At the present time, new dental schools have been established in Manitoba, Saskatchewan and British Columbia, and each school but Saskatchewan is now turning out graduates. This should slowly improve our ratio of dentists to population - (1:2722). At the same time we are hopefully looking forward to the near future when dental auxiliaries will be legally permitted to assume a more helpful role on the dental team. Dental equipment, materials and

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Ten years ago, Alberta was the only western province with a dental school. At the present time, new dental schools have been established in Manitoba, Saskatchewan and British Columbia, and each school but Saskatchewan is now turning out graduates. This should slowly improve our ratio of dentists to population - 1:3000. At the same time we are hopefully looking forward to the same future when dental auxiliaries will be legally permitted to assume a more helpful role on the dental team. Dental equipment, materials and procedures also have been steadily improving each year, so that the productivity of the average dental office has been constantly rising.

All of these factors will permit the dental demands of our people to be more balanced with our means of meeting these demands. At the present time (1871), the number of children in Alberta age 6 and under totals 228,097*. Of these, only about 125,000 - 150,000 are old enough to require dental attention. The possible number of children that could be treated under the plan increases 35,000 - 40,000 per year over the next 10 years. We believe the dental profession will be capable of fulfilling their commitment to this plan, if our recommendations are followed.

II Treatment and Services

It is proposed that only basic treatment and preventive services be provided. However, this could be made as comprehensive as is wished by Government and the Association.

III Financial Arrangements

(a) A potential contract holder would apply to the Service Corporation for a contract. The application would be processed by the Corporation, which would contact Government for approval for payment of the Government portion of the premium cost, if the applicant qualified. The applicant then, on payment of his own

*Alberta Bureau of Statistics Bulletin, April 1968.

share of the premium cost, if applicable, would be registered.

(b) The contract holder would be free to go to the dentist of his choice, and the dentist would reserve the right to accept or refuse patients as at the present.

(c) The patient would be responsible for payment of the "co-insurance factor" directly to the dentist.

Explanatory Notes

In the context of this brief

(1) Indemnity is the part of the patient's costs for services that is provided under terms of the contract on the basis of a fixed pre-arranged schedule of indemnity.

(2) The co-insurance factor is the non-specified amount or sum being the difference between the dentist's "usual" fee and the specified benefit provided by the insurance carrier and as listed in the schedule of benedits. This is the patient's personal responsibility to the dentist who provides the service and is paid directly by the patient to the dentist or by the Government, if the patient is being subsidized.

(3) The usual fee is the fee normally charged by the dentist for rendering a given service. It takes into account many variables -

- the nature and complexity of the service
- the time involved in rendering the service
- the responsibility entailed in rendering the service
- the overhead cost
- the geographic area

Co-Insurance

From all standpoints the indemnity or benefit form of pre-paid insurance with a co-insurance factor provides the most satisfactory means of providing protection against predictable and unpredictable costs of dental treatment service. There are many advantages, notably:

I It motivates patients to make diligent use of all known preventive health measures. Those who do carry out their share of responsibility benefit from fewer co-insurance costs.

II Sound precedent exists to support strongly the view that the best housekeeping is to be found where consumers of goods or services accept the responsibility for payment in full or in part to the purveyor of such goods or services, rather than where payment is solely the responsibility of some third party.

III The development of trust and credit is an incentive to good contractual behavior, certainly to be preferred to a set of rules in a disciplinary code of "do's and dont's" imposed by an interested third party and which could only be an impingement, if not an infringement, on the "Doctor-Patient" relationship. By fostering this better individual responsibility and better "Doctor-Patient" relationship, the co-insurance-indemnity-benefit plan eliminates the third party discipline over what are highly personal affairs.

IV It gives the patient an opportunity to better evaluate and appreciate the services offered, and a choice in the selection of

treatment he may wish for himself in those classes of treatment where such a choice may exist - e.g. in restorative dentistry. It is this flexibility that is so essential in the preservation of a degree of individual human dignity in maintaining a measure of the responsibility and free will in deciding for oneself one's wants.

V It eliminates the danger inherent in a third party assuming full financial responsibility for treatment services, namely, the eventual effect and control it will assume over the very nature of the treatment service itself. Through the control of the availability of dollars for any given service, a third party could effectively dictate the very nature of the treatment service which dentistry can provide and the patients can receive.

VI Co-insurance payment promotes better dental health because it keeps costs down. It is soon realized that prevention and regular periodic care are essential - neglect is costly. For the ultimate success of the program, dental health education and all preventive measures must be actively supported and promoted by Government and the health and teaching professions, volunteer agencies, etc.

VII To the profession the co-insurance factor is important, as it is the incentive factor that places a fair share of health responsibility upon the individual. It imbues a respect for the utilization of the profession's time and a personal interest in good business practices. It is this factor that will encourage these people to

accept their responsibility in the attainment of better dental health for their children.

Premium

If such a program is to be instituted, Government underwriting is essential with a premium structure to be determinted on available statistics.

Portability

The plan would be completely portable.

Financing and Operational Policy for an Indemnity Type of Prepaid Dental Co-Insurance

Several factors must be taken into consideration in the financing of any dental program for children.

1. Dental programs for children are dissimilar to medical programs in that child age groups are the most demanding of attention from the dental profession, whereas the older age groups have a much higher degree of utilization. The Medical Pensioners' Service, when active, reported that the cost of treatment was almost three times as high for the old age pensioners' group as for the children.

2. Prepaid medical plans are usually renewed year after year by the subscriber because the requirement for medical service is an unknown factor and could be a catastrophic cost at any time. Dental service, on the other hand, tends to be more of an elective procedure, as dental treatment may be postponed for a period

because dental disease is a recurring disease. This could lead to registration in a dental plan for one year, during which dental treatment could be completed, followed by a period during which the policy would be allowed to lapse and dental services postponed. Later, re-registration in the plan could take place. Thus, it may be necessary to provide for a substantial penalty clause for reinstatement.

3. The first years of participation in a dental plan would probably place greatest financial demand on it, because of the need for extensive treatment. Many children will be going to a dentist for the first time, with the result that treatment of accumulated dental disease will be common. However, as soon as the initial dental treatment has been completed, the patient and parent taught the advantages of proper oral hygiene, and regular dental examinations have become routine, maintenance of dental health should be less demanding on the plan. When fluoridation of communal water supplies has been widely introduced and has been in use for a sufficient period of time to favorably affect the caries susceptibility of the participants, dental requirements will be further reduced by a substantial amount. Therefore, it is reasonable to assume that with a continuing maintenance program for participating groups, plus the preventive value of fluoridation and other preventive dental health measures, the individual cost per child of a dental program would be reduced as time goes on.

4. A plan of a similar nature to that proposed has never been undertaken before, which means that guidance statistics from elsewhere are not available. Because of this, several important elements are unknown. It is impossible to accurately estimate the percentage of those eligible who will actually take part in this program, and the amount of dental treatment that will be required by the participants. These are comparatively unknown factors. This puts the determination of a premium in a precarious category, and will demand adjustments based on experience ratings.

5. The statistics available from the provision of dental services to welfare recipients are probably as accurate and functional as could be obtained for this type of plan as a basis of premium calculation. Approximately 40% of the various child groups take advantage of welfare dental services, at an average cost of $42.00 (1969) per child. However, it would be only conjecture to assume that these figures would be applicable to another group. It is conceivable that the welfare group may be more indifferent to oral health care, more liable to procrastinate in seeking dental services and less appreciative of the value of good dental health than the average child group. Any one of these factors could alter the agove statistics; thus, careful consideration and re-evaluation will be required.

Provision of Service

It is proposed that all services be provided by, or be under the

direct supervision of a licensed dentist; and that responsibility for any intra-oral procedures performed by formally trained auxiliary personnel be that of the supervising dentist. While some dental treatment services can and should be done in hospitals, most of the services will be done in private offices. These offices are supplied and equipped by the dentist himself, which is a different situation than the use of hispitals, which are paid for largely out of public funds.

Administration

It is proposed that the plan will be administered by the Alberta Dental Service Corporation, a non-profit corporation, incorporated under the Societies Act of the Province of Alberta on January 28th, 1964.

Prevention and Dental Health Education

Both from a social as well as an economic point of view, it will be necessary to actively promote and encourage all known measures which will prevent dental disease. Broadly speaking, prevention has two facets:

(a) continuing dental health education programs,

(b) fluoridation in all its aspects.

Although treatment is an important part of the solution to the dental disease problem, it would be futile to attempt to cope with the problem by treatment alone. Education, research, prevention and treatment must be implemented in order of effective priority.

With no other health program is the need for family and individual awareness, concern, know-how and action, any greater than with dental disease; so, as a necessary adjunct, the importance of a continuing dental health education program cannot be over-stressed. This program should be tax supported and must involve the co-ordinated efforts of the public, Provincial Government, local health authorities, teaching institutions at all levels, volunteer groups, and the dental and other health professions. This would require expansion, intensification and close integration of the many excellent programs that are already in operation.

Since no single preventive measure is totally effective, the program must include the promotion of all proven community, clinic and home-care measures. This includes fluoride prophylaxis pastes, topical fluoride solutions and dentrifices; also communally fluoridated drinking water, counselling in nutrition, diet and eating habits, instruction in tooth brushing and oral care habits, and the promotion of a feeling of concern among our citizens of the value of good dentition.